MEDICAL REPORT

Date: (DD/MM/YYYY)

1. Name: _____

2. Address: _____

3. Sex: ☐ Male ☐ Female

4. Marital State: ☐Single ☐ Married

5. Blood Type: _____

6. Please examine the following medical conditions:

a. HIV Test:
b. TB Test:
c. Heart Disease:
d. High Blood Pressure
e. Malaria:
f. Liver Function:
g. VDRL Test:
h. TPHA Test:

Please attach a photo taken in the last 6 month

In the opinion of the examining physician, is the candidate fit for this fellowship? _

Seal of Hospital or Clinic: _____

Name of Doctor: _____ Signature: _____